Practice Formation: Learning from National Studies

Maryland Health Care Commission

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Roadmap

- National picture
- Factors facilitating practice consolidation
- Practice structure, quality, and access
- Practice structure and other market effects
- Advantages and disadvantages of consolidation
- Paths to encouraging the right kind of consolidation

National distribution of physician practice size and type

Practice type	Percent in 2005	Change from 1997
Solo/2-person	32.5	- 8.2*
Small group, 3-5	9.8	- 2.4*
Medium group, 6-50	17.6	+ 4.5*
Large group, >50	4.2	+ 1.3*
Medical school	9.3	+ 2.0*
Group/staff HMO	4.5	- 0.5
Hospital	12.0	+ 1.3
Other	10.1	- 1.8*

Data from the Community Tracking Study Physician Surveys

Consolidated physician markets from the Community Tracking Study

- Highly consolidated – Cleveland, Greenville
  - Two dominant hospital systems
  - Increasing hospital employment of some specialists
  - Few independent practices of any kind

- Moderately consolidated – Indianapolis, Boston
  - Strong physician hospital organizations
  - Balanced and competitive hospital market
  - Single-specialty groups in IN but not BO

Communities with more diffuse physician markets

- Order of “diffuseness” – Miami, N. New Jersey, Phoenix, Little Rock, Syracuse, Seattle
  - Several moderately sized multi-specialty groups
  - Similar to national distribution

- Bi-modal – Orange County, Lansing
  - Small number of very large multi-specialty groups
  - Many solo and small practices
  - Nothing in between

Single-specialty groups do not thrive in highly consolidated markets

- Markets with prominent single-specialty groups
  - Indianapolis: cardiology, orthopedics
  - Little Rock: cardiology, surgery
  - Phoenix: cardiology, orthopedics, other surgery
  - Seattle: orthopedics, OB/GYN
  - Syracuse: cardiology

Factors facilitating formation of large multi-specialty groups

- Capitation (or history thereof)
- Consolidated health plan markets (Indianapolis)
- Consolidated hospital markets (e.g., Cleveland)
- Collaborative culture (e.g., Seattle)
- Payer expectations for efficiency (e.g., pay-for-performance, resource use profiling, HIT requirements)

Factors facilitating formation of large single-specialty groups

- Loose provider networks (shift to PPOs)
- Permissive certificate-of-need laws for hospitals, ambulatory surgical centers (ASCs), other free-standing facilities
- Proceduralists better able to take advantage of favorable market conditions than cognitive specialists

Multi-specialty practice structure and quality of care

- Patients in larger groups tend to:
  - Receive more recommended preventive care
  - Receive more services in general
  - Have better intermediate outcomes
  - Be somewhat less satisfied with interactions
- Physicians in larger groups are more likely to:
  - Have access to information technology and care management tools
  - Be high performers on standardized metrics
  - Engage in systematic quality improvement

Practice structure and access to care

- Large practices can market to specific patient subgroups
- Geography, geography, geography
- Competition for non-physician staff
- Some practice structures offer physicians alternatives to participation on traditional medical staffs at general hospitals → decreased or more expensive call coverage
- Improved payer mix at the cost of access to care for broader populations?

Physicians not accepting any new Medicaid patients

Practice type	Percent in 2005	Change from 1997
Solo/2-person	35.3	+ 6.3*
Small group	24.0	+ 7.8*
Medium group	12.0	+ 2.0
Large group	13.3	- 1.7
Group/staff HMO	13.5	- 1.6
Institutional setting	6.6	- 1.7
Other	18.9	- 0.1

Data from the Community Tracking Study Physician Surveys

Practice structure and prices and health care costs

- Contracting leverage of larger groups depends on level of health plan consolidation
- Larger groups with high performance can earn more through performance-incentives → price/quality cycle
- Investments in ancillaries and facilities can lead to
  - Supplier-induced demand, increased service volume
  - Competition for general hospitals
  - Favorable selection away from general hospitals

Larger practice size modestly reduces fragmentation

Practice type	Network size	Standardized network size per 100 Medicare patients
Solo/2-person	125 (73-179)	61 (41-93)
Large group	90 (48-148)	39 (25-67)
Medical school	65 (36-109)	53 (40-67)

To consolidate or not consolidate? The physician's perspective

- Capital, economies of scale to invest in equipment and facilities for diagnostic testing and procedures
- Improved negotiating leverage with health plans
- Ability to market as a "high-quality" group
- Autonomy over management decisions
- Proceduralists (in single-specialty groups) don't have to subsidize cognitive providers
- Lifestyle benefits

To consolidate or not consolidate? The policymaker's perspective

- Not all groups are the same
  - Multi-specialty groups probably better able to ensure coordination and comprehensiveness of care
  - Integration is at least as important as practice size
- Not all physician services need to be consolidated
  - Benefits of larger practices probably more critical for primary care and specialty care of common chronic conditions than incidental services (e.g., ophthalmology)
- Not all markets can consolidate
  - Sometimes culture and history trump

Paths to encouraging constructive consolidation

- Improve the business case for multi-specialty groups
  - Tiering (direct or indirect)
  - Lure of patient volume based on public reporting of standardized performance (clinical, cost, patient experience)
  - Direct financial incentives for quality, coordination based on measures targeting comprehensive care of the patient
- Encourage integration of health systems generally
  - Remove gainsharing barriers (e.g., to support HIT adoption)
  - Incentives for “service agreements”
  - Share data on care patterns with physicians